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SUBJECT: HIV/AIDS IN THE DRC: AN EVOLVING EPIDEMIC

¶1. Background note: Embassy Kinshasa recently completed a Partnership Framework with the Government of the Democratic Republic of Congo (DRC) and hired a full-time PEPFAR coordinator. This message provides general information about the HIV/AIDS epidemic in the DRC. It has been cleared by all PEPFAR team agencies and sections. End background note.

¶2. Summary: The DRC has a generalized HIV epidemic, though recent surveillance study data shows increasing prevalence rates in various hotspots across the country. High prevalence areas include 8.7% in urban Kisangani, Oriental Province (8.7%) and rural Kasumbalesa, Katanga Province (16.3). Higher prevalence populations include the military (11.8%) and sex workers (23.3%). End summary.

1.2 million Congolese estimated to be HIV positive

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¶3. Almost 1.2 million Congolese will be infected with HIV by the end of 2010, and almost 300,000 Congolese will be eligible for antiretroviral treatment (ART) by 2010 according to the UNAIDS modeling program for HIV estimates (2008 Antenatal Care -- ANC -- Surveillance Report). However, due to resource limitations, only 67,000 HIV positive people will be covered with treatment over the next five years. The DR Congo 2009 Orphans and Vulnerable Children (OVC) Rapid Assessment, Analysis, and Action Plan (RAAAP) Situational Analysis estimates that there are 8.2 million OVC with over 1 million of these children orphaned due to HIV/AIDS.

¶4. In 2008, HIV prevalence among pregnant women attending antenatal care (ANC) sentinel sites in DR Congo was 4.3%, with prevalence as high as 8.7% in urban Kisangani (Orientale Province) and 16.3% in rural Kasumbalesa (Katanga Province). Other high prevalence locations include urban Lubumbashi (6.3%), Mbuji Mayi (5.8%), and Mbandaka (5.4%); and rural Neisu (5.4%), Lodja (4.8%) and Kasongo (4.8%).

Estimates of HIV prevalence vary

¶5. There are signs that the epidemic may be changing. Although data from the 2007 Demographic and Health Survey (DHS) suggests that HIV prevalence may be declining, the recent antenatal surveillance data, collected annually since 2004, does not support this conclusion. The 2007 DHS estimates HIV prevalence in the general population at 1.3%, with higher prevalence among women (1.8%) and in urban areas (1.9%); however, the 2008 ANC surveillance data suggests that the prevalence may be higher in rural sites (4.6% compared to 3.7% in the capital of Kinshasa and 4.2% in other urban areas). Differences in DHS and ANC estimates are typical due to the different populations sampled. The 2007 DHS is the first survey of this kind in DRC. The Government of the Democratic Republic of Congo (GDRC) prefers to continue to use ANC data to estimate general prevalence. Using ANC surveillance data for women ages 15-24 as an indicator of where the epidemic may be focused in upcoming years, high prevalence is in Kasumbalesa (14.2%), Kisangani -(7.6%), Kasongo (5.4%) and in Lodja, Buta and Mwene Ditu (5.2%), compared to 2.7% prevalence among 15-24 year olds in Bukavu, a current USG geographic focus point where overall ANC prevalence is 1.6%. Bukavu, like Kisangani, is on a major regional transport corridor and therefore continues to be at risk of rapid spread of HIV infection.

¶6. Among women, the highest prevalence is between ages 40-44

(4.4%). For women, those who are the most educated and wealthiest are at greatest risk (3.2% and 2.3%, respectively) when compared to the least educated and poorest women (0.6% and 1.2%, respectively). In relation to marital status, widowed women have the highest prevalence (9.3%). For men, the highest prevalence occurs between 35-39 years (1.8%), according to 2007 DHS. Risk of infection is higher among men and women living in urban areas than those living in rural areas (1.9% versus 0.8%, respectively) according to the 2007 DHS. HIV prevalence is highest for women in Kinshasa (2.3% compared to 1.0% in the West, 2.1% in the East, and 1.6% in the Central South). For men, however, the highest prevalence is in the East (2.1% compared to 1.3% in Kinshasa, 0.5% in the West, and 0.8% in the Central South). Most At Risk Populations (MARPs) have much higher prevalence rates compared to the general population according to Behavioral Surveillance Studies (BSS). For example, HIV prevalence is 23.3% among sex workers in Lubumbashi (2004) and 11.8% among military personnel (2008).

Tuberculosis (TB) is also a major problem

¶7. The DRC now ranks 10th among the world's 22 high-burden tuberculosis (TB) countries. The estimated incidence of TB was 392 cases per 100,000 population in 2007, according to the World Health Organization. HIV prevalence in adult-incident TB patients is estimated to be 17% in USG-supported clinics in Kinshasa.

¶8. An estimated 141,500 HIV+ women in DR Congo delivered 42,450 children infected through mother to child transmission in 2008 (2008 National HIV/AIDS Control Program (PNLS) report). According to the National AIDS Control Program (PNLS), only 5% of eligible pregnant women have access to prevention of mother to child transmission (PMTCT) services according to the 2008-2012 DRC HIV/AIDS Strategic Plan. Despite up to 88% of women accessing antenatal care services, PMTCT and counseling and testing services are minimal to nonexistent.

Demand for counseling and testing is high

¶9. Demand for HIV Counseling and Testing (HCT) services in the DR Congo is high; however, the low percentage the population that knows their HIV status (9% for both men and women) may contribute to fueling the epidemic (2007 DHS). Fewer than 30% of people living with HIV/AIDS enrolled in ART programs are receiving some form of palliative care. Based on the 2008 National HIV/AIDS Control Program (PNLS) report (published in late 2009), 24,245 patients were enrolled on ART, which represents 40.4% of the 2008 target (60,000 PLWHA planned by the end of 2008 based on potential availability of resources). Currently, the PNLS estimates that 31,000 people are enrolled on ART, which is only about 10% of those eligible.

¶10. Epidemiological information has been used by USG and GDRC in the development of the Partnership Framework to focus limited USG resources (specifically PEPFAR funds) on most at risk populations in selected high prevalence geographic areas within the context of the DRC National Multi-sector Strategic Plan for 2010-2014. PEPFAR funding complements considerable resources provided to the DRC by the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as the World Bank's Multisector AIDS Program, and smaller contributions by UNICEF, the Clinton Foundation, and other bilateral partners. However, current resources are insufficient to address the country's real needs.
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